Cordell Mitchell, M.D.
Obstetrics and Gynecology

974 Douglas Avenue, Suite 102
Altamonte Springs, Florida 32714
407-862-1550

Medical Records Release Authorization

Date:_____

Patient Name: _____ S.S.#:_____

Address:_____

City/State: _____ Zip Code: _____

_____ I hereby authorize and request that my medical records be release to Dr. Cordell Mitchell at 974 Douglas Ave. Suite # 102, Altamonte Springs, Florida 32714, or faxed to 407-862-6042. These records will include ALL treatment given, medical history, lab reports, X-rays, and other vital reports and information.

_____ I authorize Dr. Cordell Mitchell to release my medical records to:

Name: _____

Address:_____

City/State: _____ Zip Code:_____

Phone #: _____ Fax #: _____

_____ I authorize Dr. Cordell Mitchell to release my medical records to myself.

Patient Signature:_____ Date:_____

Witness: _____ Date: _____